TEMPORARY POSTGRADUATE TRAINING PERMIT
TRAINING PERMIT PROCESS – INFORMATION FOR APPLICANTS

The Medical Board's Licensing Section works to protect the consumer through the proper review and licensing of physicians (MDs and DOs). The comprehensive review of an application provides that licensees have the requisite qualifications and education credentials per Georgia law so that they may practice medicine.

While the licensing staff understands the sense of urgency experienced by each applicant, they are responsible for reviewing many files and staff cannot complete the review of a file if the required documentation is missing. It is imperative for applicants to understand that the review process is guided by the requirements set for in State law, which does not provide for any waivers to be granted by staff.

1. We will discuss the application status with the applicant and Program Director ONLY associated with the temporary training permit.
2. Applications are reviewed in the date order of receipt.
3. Applicants should submit all required documentation as soon as possible; however, without both the application and fee, staff cannot begin the initial review process.
4. All fees are **nonrefundable**.

Once an application for a temporary residency-training permit has been received, staff must complete the initial review within **30** days. The applicant is then notified in **writing** of the application status and given an itemized list of documents needed to complete the file (if required).

A $100.00 **nonrefundable** fee should be submitted along with your application. Board regulations require you to keep the Medical Board informed of changes in address for mailing and work, and associated phone numbers. Please use the checklist below to ensure that you have enclosed all the required documents:

APPLICANT CHECKLIST

☐	**$100 Application Fee Enclosed**
☐	**Basic Information Form Enclosed – Page 3**
☐	**Applicant Questionnaire Enclosed – Page 4**
☐	**Certificate of Postgraduate Training Form completed, signed by Program Director, and notarized. – Page 5**
☐	**Affidavit of Applicant Form and Photo Enclosed – Page 6**
☐	**VERIFICATION STATEMENT -** **Graduate Medical Education Committee (GMEC) & Parent Program Form Completed and Signed (if applicable) – Page 7**
☐	**Evidence of graduation from a medical or osteopathic school approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) or the Liaison Committee on Medical Education Enclosed; or**
☐	**If a graduate of a "foreign" medical school, evidence of holding a valid certificate issued by ECFMG or having successfully completed a fifth pathway program established in accordance with AMA criteria and passing the ECFMG qualifying medical component examination enclosed.**
☐	**Other – (Please describe)**

APPLICATION
FOR
TEMPORARY POSTGRADUATE TRAINING PERMIT

BASIC INFORMATION

INSTRUCTIONS: Provide your <u>full</u> legal name, in the format indicated on the application. This is the name that will be printed on the permit card, reported to hospitals and those who inquire about your training permit.

In order to be considered for a temporary Postgraduate Training Permit, you must provide one of the following: 1) Evidence of graduation from a medical or osteopathic school approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) or the Liaison Committee on Medical Education; or 2) If a graduate of a "foreign" medical school, evidence of holding a valid certificate issued by ECFMG or having successfully completed a fifth pathway program established in accordance with AMA criteria and passing the ECFMG qualifying medical component examination.

LAST NAME	FIRST NAME	MIDDLE NAME

MAIDEN NAME (IF APPLICABLE)	DEGREE (MD OR DO)

Other names under which material may be submitted – Do not use nicknames	NAME OF MEDICAL SCHOOL	GRADUATION DATE

DATE OF BIRTH (MM/DD/YY)	CITY	STATE	COUNTY	

US Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

This information is authorized to be obtained and disclosed to state and federal agencies by O.C.G.A. § 19-11-1 and O.C.G.A. § 20-3-295, 42 U.S.C.A. § 651 and 20 U.S.C.A. § 1001. This information also **may** be disclosed to the National Practitioner's Data Bank (NPDB) or other state medical boards or regulatory agencies for license tracking purposes.

❑ **I do <u>not</u> wish this information to be released to the NPDB or other medical boards or other regulatory agencies for license tracking purposes.**

INSTRUCTION: Provide your mailing address. Board Rules and Regulations require that you keep the Board informed of any address changes to include street address, city, state, zip code, and phone number. If you have an address change during the application process, you may fax this change to 404-651-7864. This should include the old address and the change. The importance of your address is evident during the renewal process as training permits expire annually on June 30. <u>NOTE: FOR TEMPORARY TRAINING PERMIT HOLDERS, YOUR BUSINESS ADDRESS WILL BE USED AS THE PRIMARY MAILING ADDRESS TO RECEIVE MAIL FROM THE BOARD.</u> The address you provide should be an address that you do not mind having posted on the internet. The Board does require a street address for its records if you use a PO Box as your mailing address.

RESIDENCE STREET ADDRESS			APARTMENT #
CITY	STATE	ZIP CODE	COUNTY
(AREA CODE) PHONE NUMBER	(AREA CODE) FAX NUMBER (OPTIONAL)		E-MAIL ADDRESS (OPTIONAL)

BUSINESS STREET ADDRESS			SUITE #
CITY	STATE	ZIP CODE	COUNTY
(AREA CODE) PHONE NUMBER	(AREA CODE) FAX NUMBER (OPTIONAL)		E-MAIL ADDRESS (OPTIONAL)

TEMPORARY POSTGRADUATE TRAINING PERMIT
APPLICANT QUESTIONNAIRE

If you answer, "YES" to questions 1-20, you are required to furnish complete details, including date, place, reason and disposition of the matter. Failure to furnish the documentation may result in a delay in the application process.

		YES	NO	GMB
1.	Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse during the last seven years? (If you answer yes to this question, provide letter(s) from all treating physician(s) directly to Board.)	❑	❑	❑
2.	Have you ever been arrested for and/or convicted of a violation of any Federal (including military), State or Local State statute?	❑	❑	❑
3.	Have you ever been denied the privilege of taking an examination given by any licensing Board or agency?	❑	❑	❑
4.	Has any licensing Board or agency ever denied you a certificate or a license?	❑	❑	❑
5.	Has any licensing Board or agency ever refused you renewal of a certificate or a license?	❑	❑	❑
6.	Have you ever been denied a DEA registration number?	❑	❑	❑
7.	Have you ever been issued a restricted DEA registration?	❑	❑	❑
8.	Are you currently registered with the DEA? If you are registered with the DEA, provide the number and state of issue below: _____ State of issue_____	❑	❑	❑ ❑
9.	Have you ever had any malpractice suits filed against you?	❑	❑	❑
10.	Have you ever been denied membership in or in any way sanctioned by any medical or osteopathic association, society, or specialty society?	❑	❑	❑
11.	Have you ever resigned from a hospital staff position or training program after a complaint or peer review action has been initiated against you?	❑	❑	❑
12.	Have you ever voluntarily surrendered a medical license?	❑	❑	❑
13.	Have you ever voluntarily surrendered a controlled substance registration?	❑	❑	❑
14.	Have you ever voluntarily surrendered a DEA registration?	❑	❑	❑
15.	To your knowledge, are you the subject of an investigation by any licensing Board or agency as of the date of this application?	❑	❑	❑
16.	Do you have any applications for licensure pending before any other licensing Board or agency?	❑	❑	❑
17.	Have you ever had any restrictions as a Medicaid or Medicare provider?	❑	❑	❑
18.	Are you in default on a state or federally funded and/or guaranteed school loan?	❑	❑	❑
19.	Are you in default on child support payments?	❑	❑	❑
20.	Have you ever transferred from one graduate medical education program to another?	❑	❑	❑
21.	Have you ever been terminated from a graduate medical education program?	❑	❑	❑
22.	Have you ever resigned from a graduate medical education program?	❑	❑	❑

TEMPORARY POSTGRADUATE TRAINING PERMIT

C E R T I F I C A T E O F P O S T G R A D U A T E T R A I N I N G

INSTRUCTION: To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

Rule: Chapter 360-2-.02(1) Applications for a medical license must be complete, including all required documentation, signatures and seals. . .

PART 1: To be completed by the Applicant

LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH	TELEPHONE NUMBER HOME: WORK:

CURRENT TRAINING PROGRAM BUSINESS ADDRESS:
(NOTE: This address will be used as the primary mailing address to receive mail from the Board)

CITY	STATE	ZIP CODE

PART 2: To be completed by the Program Director

PROGRAM DIRECTOR'S AFFIDAVIT

TYPE OF PROGRAM (CHECK ONE)

Post Graduate Year: ☐
Clinical Fellow: ☐

Name of Training Program:

Beginning date of training:	Projected Program Completion Date:	
_____	_____	

This portion of the application must be completed by the Program Director who is licensed in this State.

I hereby recommend the above applicant be granted a postgraduate training permit. I hereby certify that he/she will limit his/her practice to such acts as may be prescribed by or incidental to the training program, that he/she may train only under the supervision of physicians responsible for supervision as part of the training program and may practice in facilities affiliated with the program only if such practice is part of the training program for which the permit is granted. I hereby recommend the above applicant be granted a postgraduate training permit. I hereby certify that he/she will limit his/her practice to such acts as may be prescribed by or incidental to the training program, that he/she may train only under the supervision of physicians responsible for supervision as part of the training program and may practice in facilities affiliated with the program only if such practice is part of the training program for which the permit is granted. **I understand that I must report to the Board the following within 15 days of the event: any disciplinary action taken against the permit holder for any ground or violation enumerated in O.C.G.A. §§ 43-34-37 and 43-1-19, the permit holder's withdrawal or termination from or completion of a postgraduate training program or the permit holder leaving the program for any length of time in excess of two weeks.**

Please type or print:

_____
Program Director's Name Title

_____
Signature

HOSPITAL SEAL OR NOTARY STAMP MUST BE IMPRINTED HERE

Sworn to and subscribed before me this

_____ day of _____, _____
DATE MONTH YEAR

SIGNATURE OF NOTARY PUBLIC

_____

EXPIRATION STAMP must be stamped here

TEMPORARY POSTGRADUATE TRAINING PERMIT
AFFIDAVIT OF APPLICANT

TOP OF PHOTO (HEAD)

PHOTO AREA
PASTE A 2 ¼" X 3"
PHOTO HERE.

PHOTO MUST BE OF
YOUR HEAD
AND SHOULDER AREAS ONLY

Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided would be used to determine your qualifications for a temporary postgraduate training permit per Georgia Law that authorizes collection of this information. The information on your application may be transferred to other medical licensing authorities the Federation of State Medical Boards or other governmental or law enforcement agencies.

I acknowledge and state that I have read the Application for Temporary Postgraduate Training Permit Information and Applicant Instructions that accompanied this application and I have answered all questions in compliance with these instructions. I acknowledge that it is my responsibility to read and become familiar with the Medical Practice Act and the Board Rules, copies of which are sent to applicants.

I further state that by filing this application for a temporary postgraduate training permit to practice medicine in the State of Georgia; I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine. I agree to give any further information, which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its content and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board or Court Order.

I request and authorize any treatment program to release alcohol and drug abuse patient records to the Composite State Board of Medical Examiners for the purpose of evaluating my fitness to practice. The consent of this paragraph is subject to revocation pursuant to federal regulations and terminates upon the date of termination of my training permit in Georgia.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or International), court, association, institution, or other organization having control of my documents, records and other information pertaining to me, to furnish to the Georgia Composite State Board of Medical Examiners any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Georgia Composite State Board of Medical Examiners or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice there under.

I authorize and request the Georgia Composite State Board of Medical Examiners to obtain any criminal history information concerning me from any authorized law enforcement agency, including but not limited to the Georgia Crime Information Center (GCIC) and the National Crime Information Center (NCIC).

I hereby release to the Board, its staff and their representatives, any and all documentation necessary now and in the future to evaluate my qualifications to practice medicine, including, but not limited to my moral character, professional reputation and fitness to safely practice medicine.

I hereby release, discharge, and exonerate the Georgia Composite State Board of Medical Examiners, its agents or representatives, and any person so furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records or other information or the investigation made by the Georgia Composite State Board of Medical Examiners.

I authorize the Georgia Composite State Board of Medical Examiners to release information, material, documents, or the like relating to me or to this application to any other State or Territory of the United States or Province of Canada, a law enforcement agency, hospital or other appropriate agencies as determined by the Georgia Composite State Board of Medical Examiners.

This is to certify that the forgoing information is true and correct to the best of my knowledge. I understand that pursuant to the Official Code of Georgia Annotated, Section 43-34-46, any person who shall give false or forged evidence of any kind to the Board in connection with an application for a license to practice medicine shall be guilty of a felony and upon conviction thereof, shall be punished by a fine of not less than $500.00 nor more than $1,000.00, or by imprisonment from two to five years, or both.

I understand that I must limit my activities under the training permit to such acts as may be prescribed by or incidental to the training program, that I may train only under the supervision of physicians responsible for supervision as part of the training program, and may practice in facilities affiliated with the program only if such practice is part of the training program.

SIGNATURE OF APPLICANT | DATE | CITY | COUNTY | STATE

PRINTED NAME OF APPLICANT

_____

Being duly sworn, says that he/she is the person who executed the above application for a temporary postgraduate training permit in the State of Georgia; and that all the statements herein contained are true in every respect and that the attached photo is a true photo of the applicant. In addition, I will immediately notify the Board in writing of any changes to the answers to questions contained in the Applicant Questionnaire if such a change in answer is warranted at anytime, prior to being granted a temporary postgraduate training permit by the Georgia Composite State Board of Medical Examiners.

NOTARY SEAL MUST BE IMPRINTED HERE

Sworn and subscribed to me this _____day of _____, _____

_____(Notary Public)

My Commission Expires

_____

T E M P O R A R Y P O S T G R A D U A T E T R A I N I N G P E R M I T
V E R I F I C A T I O N S T A T E M E N T F O R N O N - S T A N D A R D T R A I N I N G P R O G R A M
Graduate Medical Education Committee (GMEC) & Parent Program

The following institution and program seek approval to consider physician applicants for participation in a non-standard training program that operates in direct association with an ACGME-accredited parent program.

Name of Non-Standard Subspecialty Training: _____

Name of Host Institution: _____

ACGME Institution ID Number: _____

Name of Parent Program Specialty/Subspecialty: _____

Parent Program ACGME Program ID Number: _____

The Graduate Medical Education Committee (GMEC) Chair/Director, Program Director of the ACGME-accredited parent program, and ECFMG Training Program Liaison confirm the following:

1. The GMEC approved the above-mentioned non-standard training program/pathway and curriculum. **(Please attach the approved program description).**
2. The institution is in full compliance with ACGME requirements as evidenced by a “Favorable” action on its most recent institutional review.
3. All accreditable programs within the institution are in good standing with the ACGME.
4. The non-standard training program/pathway is directly associated with the ACGME-accredited parent program referenced above.

_____ _____
Chair, Graduate Medical Education Committee (Print Name and Sign) Date

_____ _____
Director, Office of Graduate Medical Education (Print Name and Sign) Date

_____ _____
Program Director, ACGME accredited Parent Program (Print Name and Sign) Date

_____ _____
ECFMG Training Program Liaison (Print Name and Sign) Date